P.O. BOX

Update on the Happenings of CMS's Managed Care Systems and Support Operations

Division of Enrollment and Payment Operations, HPBG, CBC – Centers for Medicare & Medicaid Services (formerly, HCFA)

INSIDE THIS ISSUE

NEW RISK ADJUSTMENT REPORT COMING FOR 2004

The Risk Adjustment payment method is changing for 2004. Details of the new payment method are contained in the Advance Notice of Methodological Changes for Calendar Year (CY) 2004 Medicare+Choice (M+C) Payment Rates, dated March 28, 2003: it is located at the CMS website http://cms.hhs.gov/healthplans/rates/2004/45day.pdf.

Risk adjustment factors will be computed based on specified disease groupings using the CMS Hierarchical Condition Category (CMS-HCC) model. The outputs of this model replace the PIP-DCG score used since 2000 to calculate risk adjustment payments. There can be up to 64 different disease groups for an individual plus numerous disease interactions.

This information is too voluminous to be contained on the monthly membership report. A separate report and data file containing the CMS-HCC model outputs will be available in GROUCH. Information regarding the layouts and instructions on downloading will be provided later this year.

LETTER ON 2004 MANAGED CARE SYSTEMS CHANGES RELEASED

On June 19, 2003, a letter was released providing additional details for items related to enrollment and payment system changes that were included in the Instructions for the 2004 Contract Year (dated June 6, 2003).

Specifically, information was provided for the following items.

The Monthly Membership Data File and Report (MMR)

The formats were revised to support the new risk adjustment payment process that will begin January 2004. New fields include the Risk Adjustment Factor Type and the Institutional Flag. Details of the new payment method are contained in the Advance Notice of Methodological Changes for Calendar Year (CY) 2004 Medicare+Choice (M+C) Payment Rates, dated March 28, 2003. It is located at the CMS website http://cms.hhs.gov/healthplans/rates/2004/45day.pdf.

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Working Aged Process

The revised managed care organization contract-level(H-number) Working Aged Process replaces the current beneficiary-level reconciliation process. Once each year, MCOs will report directly to CMS those members who are working aged. CMS will compute a MCO (H number)-level factor which will be applied to the monthly payment. MCOs will continue to submit working aged information and CMS will continue to process adjustments for pre-2004 timeframes. MCOs have a few months in 2004 to submit data for these pre-2004 periods.

Employer Group Health Plan (EGHP) Status Reporting

In mid-2004, MCOs will identify their EGHP members to CMS. For current membership, reporting will be via EXCEL listings and should be at the plan benefit package (PBP) level for EGHP-only plans or at the member level for plans with both EGHP and Non-EGHP enrollees. A field has been added to the enrollment transaction to report this information for new members.

Default Application Signature Date

In some circumstances, CMS allows movement of your members to alternate plans under your organization without a signed application. This is referred to as a "passive election". The plan is basically the same, but the plan number is changing due to administrative reasons. In these cases, the M+CO submits PBP election transactions. On such transactions, the application signature date is required. Since the member has not signed an application for this move, a default date may be used. This default date is the first day of the month of the month preceding the effective date of the plan change.

PLAN PAYMENT LETTER: 820 FORMAT GOES LIVE

The ASCX12N 820 version of the Plan Payment Letter will be available via production GROUCH, effective with the August 1, 2003 payment. Even though the 820 format is available; it not intended to replace your current Plan Payment Letter. They both will be available for your use. Please note that the use of the 820 standard transaction will not affect how your payments are made and will not be used to transmit your payment through the banking system. It will only be used to provide limited information about your payment: total membership, gross payment and total net payment. You will continue to receive detailed payment adjustment information from the Plan Payment Letter.

If you have any questions, please call James Dorsey at (410) 786-1143.

MCCOY AVAILABLE EARLIER THAN GHP SCHEDULE INDICATES

To complete monthly processing, MCCOY is scheduled to be unavailable each month for three days. The processing consists of various production jobs that would interfere with MCCOY operations. These production jobs for the past few months have had excellent run times and, as a result, MCCOY was brought back up two days earlier than scheduled.

The down days for MCCOY are indicated on the GHP monthly schedule. To determine if MCCOY has come up earlier than planned, log on to the HDC mainframe, select M204 (Prod2) , or number '5', from the selection menu. If MCCOY is up, 'AVAILABLE' will show next to MCCOY. If 'UNAVAILABLE' shows, monthly processing is continuing.

MANAGED CARE ENROLLMENT AND PAYMENT CONFERENCE

The annual Medicare **Managed Care Enrollment and Payment Conference** will be held September 18th –

19th, 2003, at the Wyndham Inner Harbor Hotel in Baltimore. In addition, a **Basic Training Session** will be held on September 17th, 2003, at the CMS national headquarters in Baltimore. This conference will assist the Medicare managed care contractors in understanding how regulations, policies and program development for 2004 will affect the day-to day operations of Medicare managed care enrollment and payment departments.

The conference has been divided into two separate information tracks in order to present information to Managed Care staff who are new to the business and to those who have experience with the business for a period of time.

The main conference will focus on annual program developments and updates. These sessions are designed for both new and veteran participants of Medicare Managed Care.

The basic training is specifically geared toward new, inexperienced staff and will actually train staff on accessing the Managed Care systems, and interpreting reports.

Registration information will be available July 1, 2003 on CMS Web site. Please go to http://cms.hhs.gov/healthplans/systems/ and then click on Calendar of Events – Training and Conferences and select either the "Managed Care Enrollment and Payment Conference" or the "Basic Training Session". If you have any programmatic questions, please contact Jim Dorsey, CMS, at 410-786-1143, or e-mail at jdorsey1@cms.hhs.gov. If you have registration questions, contact Esmee Arthurton, AFYA, Inc., 301-270-0841, ext. 257 after July 1, 2003.

INTEGRIGUARD BEGINS PROBE STUDIES

IntegriGuard does not require M+COs to submit their supporting documentation with requests for retroactive adjustments to the state and county code and the health status categories. However, in order to assure appropriate oversight of these retroactive adjustments submitted by M+COs, IntegriGuard will periodically conduct a probe study and request the supporting documentation from the M+COs. The purpose of the probe study is to review and verify that M+COs are maintaining the required documentation, as outlined in the Standard Operating Procedures (SOP) developed by CMS.

IntegriGuard provides a list of specific retroactive adjustments submitted by your plan and you must submit copies of the supporting documentation to IntegriGuard within 7 working days from the date of the letter.

If you are unable to submit adequate supporting documentation within the timeframe specified, IntegriGuard may reverse the specific retroactive adjustments included in the PROBE study. In addition, the privilege of submitting requests for these types of retroactive adjustments without supporting documentation may be rescinded, and you will have to submit supporting documentation for all retroactive adjustment requests.

2002 HOSPICE RECONCILIATION

CMS has begun the process to reconcile Hospice payment for 2002. CMS anticipates completing the analysis and applying retroactive payments in the August 1, 2003 payment.

In 2003, Hospice payments will be paid at the Plan Benefit Package (PBP) level. Hence, the 2002 year will be the final time a Hospice payment reconciliation will need to be performed.